

PROGRESS OF MEDICAL SCIENCE.

MEDICINE.

UNDER THE CHARGE OF

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A Case of Suppurative Myositis Caused by Micrococcus Gonorrhœa (Neisser).—HARRIS and HASKELL (*Johns Hopkins Hospital Bulletin*, December, 1904, p. 395) comment on the multiplicity of the complications of gonorrhœa. They have searched the literature for cases of myositis following this disease, and give abstracts of 7 cases in which a myositis due to the gonococcus was believed to exist. In 6 of these a suppurative myositis was believed to exist, but the bacteriological proof was not sufficiently convincing in any single instance to definitely warrant the opinion that the gonococcus was the cause of the inflammation. Their own case concerned a woman, aged thirty-four years, who since the birth of her last child, eleven months before, had suffered from leucorrhœa. She had had it on previous occasions, and this symptom constituted the only evidence of a gonorrhœal infection. Four weeks before she was admitted to Dr. Osler's wards in the Johns Hopkins Hospital a lump the size of a hen's egg developed in the right calf muscles, giving place later to a diffuse boggy swelling. Several months before she came under observation another swelling, also about the size of a hen's egg, appeared over the lumbosacral region. The abscess in the calf muscles was aspirated and a small amount of pus obtained for bacteriological examination. The pus showed a diplococcus which in its staining and cultural characteristics conformed in every way with those of the gonococcus. The abscess was eventually incised and it was found to contain about one and a half pints of pus. It was situated beneath the gastrocnemius and soleus muscles and extended up into the popliteal space. There had been considerable sloughing of these muscles and their tendons. The abscess in the lumbosacral region was incised and was found to contain about three ounces of pus. It extended up into the erector spinæ muscles on either side, which, with their tendons, showed considerable sloughing. The bacteriological examination of the pus obtained from the abscesses at

operation demonstrated conclusively the presence of the gonococcus. A feature of interest in this case was that there was no co-existent arthritis nor was there any history of its having previously been present.

Abnormalities in the Feces in Disease of the Pancreas.—URY and ALEXANDER (*Deutsche med. Wochenschrift*, 1904, xxx. p. 1311), on the basis of a number of cases and a general survey of the literature, point to the importance of careful examination of the feces in suspected disease of the pancreas, while emphasizing the reserve which must be exercised in interpreting the results. The two points of special interest are the determination of the fat and proteid digestion. There are three possibilities in reference to abnormal fat content of the feces in pancreatic disease. There may be an increased amount of fat with diminished fat splitting, an increased amount of fat with normal splitting, or a normal amount of fat with diminished splitting. It is of great importance in these estimations to regulate accurately the amount and character of the ingested food. Fat kept within the bounds of assimilation is normally well utilized (7 per cent. to 10 per cent. loss), and the limit is high, reaching, with individual variations, about 350 grams for butter. The tolerance for fats is much diminished in disease of the pancreas, and the limit of assimilation relatively low, so that by carefully regulating and changing the diet defects in pancreatic secretion might be recognized at an early stage. Conclusions from the amount of fat in the stools can, however, only be drawn under the following conditions: There should be no jaundice, as absence of bile may of itself cause steatorrhœa; the fat should not be administered emulsified, and there should be no diarrhœa. If diarrhœa be present, it may be checked with opium. Even under these precautions the results are of value in diagnosis only when considered in relation to other symptoms. Marked steatorrhœa may occur in disease of the small intestine, with diminution of its absorptive power, and in diseases interfering with the flow of fat through the lacteals, as enlarged mesenteric glands and tuberculous peritonitis. On the other hand, one meets with cases of almost complete destruction or atrophy of the pancreas, in which, during life, fat digestion is perfect. What Ury and Alexander consider almost pathognomonic of pancreatic disease is the discharge of large quantities of liquid fat after the solid, formed feces have been passed. Most cases of steatorrhœa are associated with an excessive number of well-preserved muscle fibres in the stool, although either condition may occur without the other. This is not surprising, in view of the results which have established the independence of fat and proteid digestion. Muscle fibres, of course, occur in normal stools, and to recognize an azotorrhœa, not more than one-half pound of tender meat a day should be allowed. The significance of this condition is likewise relative and occurs in various affections disturbing the movements, secretion, and absorption of the small intestines. A third point of some importance is the evacuation of relatively large quantities of solid feces. Nobel thought the absence of the products of putrefaction was an important diagnostic aid, but Ury and Alexander found a normal amount of aromatic oxyacids in their cases. In diabetes, as a rule, both fat and proteid digestion are well preserved. In certain cases, however, with marked steatorrhœa and azotorrhœa, extensive involvement of the pancreas has been correctly diagnosed. Naunyn, however, cautions against too great reliance on these symptoms.